	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MUL A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED 06/16/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	
SUNSHIN	E CARE HOME			RYLAND AV AS, NV 89		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDERS PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLI HE APPROPRIATE DATE
	Initial Comments The findings and coby the Health Divisi prohibiting any crimactions or other claravailable to any parstate, or local laws. This Statement of Earesult of an annuaconducted in your fillings. Licensure survey wor NRS 449.150, Pother facility is licens.	ion shall not be con ninal or civil investig ims for relief that m rty under applicable Deficiencies was ge al State Licensure s acility on 6/16/10. Tas conducted by the lowers of the Health	strued as ations, ay be federal, enerated as survey This State e authority Division.	Y 000	8/4/10 NOC	XBELI 220
	Facility for Group be person and/or person and/or person and/or person Category II resident the survey was eight reviewed and six er One discharged resone discharged resone The facility received The following deficit	ons with mental illness. The census at the c	ess, he time of es were reviewed. wed.		ä	ECEIVED SET 1 > 2010 CAS VEGAS NEVAD
SS=E	449.196(3) Qualification Training NAC 449.196 3. If a caregiver assifacility in the administiculation or dietal must: (a) Receive, in additional pursuant to NRS 44 training in the mana caregiver must received.	sists a resident of a istration of any med mitation, an over-th ry supplement, the tion to the training r 19.037, at least 3 ho agement of medicat sive the training at least	residential lication, e-counter caregiver required ours of ion. The east every	Y 072 ✓	Employee #1 is the owner of a Registered Nurse by professinstructions to refrain from as administration of their medical scheduled Medication Training 2010. Henceforth administration of their medical scheduled Medication Training 2010. Henceforth administration of their medical scheduled medical sch	sion. He is under sisting residents in the ations nending his ag Seminar on July 30, after will review

Administrator JUL 2 2 2016

8/4/10

BUEFAN OF LICENSURE AND CERTIFICATION
LAS YEGAS, NEVALX

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EXPREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVAGA

Bureau o	f Health Care Quall	ty and Compliance					
	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS430AGC			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2010	
NAME OF D	ROVIDER OR SUPPLIER	1000000	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	E CARE HOME		3970 MAR	RYLAND AVI A6, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
Y 072	and his attendance (b) At least every 3	ce of the content of the at the training; and years, pass an examagement of medication	nination	Y 072			
	Based on record re failed to ensure that completed the requ	not met as evidence eview on 6/16/10, the at 1 of 6 caregivers ha uired three hour med sher training every th	facility ad ication				
Y 103 SS=E	NAC 449.200 1. Except as others a separate persons member of the state (d) The health certifications.	wise provided in subs nel file must be kept if of a facility and mu- ificates required purs AC for the employee.	section 2, for each st include: want to	Y103	The following documents are now in employees' respective files: Employee #4 – physical and TB test Employee #5 and #6 – 2 step TB test Please see attached. Henceforth, administrator will review personnel a regular basis to ensure compliance	$7/2\psi/10$ t.	
	Based on record re failed to ensure 3 of NAC 441A.375 reg testing for the prote (Employee #4 - physics)	not met as evidence eview on 6/16/10, the of 6 employees comp parding tuberculosis (ection of all residents ysical, evidence of po	facility lied with TB) sitive TB		her receipt of this statement of deficiencies		

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If continuation sheet 2 of 13

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BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA

PRINTED: 06/21/2010 FORM APPROVED

Bureau o	of Health Care Quali	ty and Compliance						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		NVS430AGC	,			06/16/2010		
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
SUNSHI	IE CARE HOME	WI .		RYLAND AVE GAS, NV 89121				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE		
Y 103	Continued From pa	age 2		Y 103				
	and annual signs a TB test and #6 - tw	nd symptoms, #5 - to o step TB test).	,					
	This was a repeat of 8/19/09 State Licer	deficiency from the 6 nsure survey.	/3/09 and					
	Severity: 2 Scope	: 2				m		
Y 105 SS=D	449.200(1)(f) Perso	onnel File - Backgrou	ind Check	Y 105	Copies of fingerprints of employee submitted on 6/25/10 to Nevada Der Public Safety, Records and Technolo	partment of 7/2//		
	a separate personi member of the stat	wise provided in subs nel file must be kept if of a facility and mu npliance with NRS 44	for each st include:		Carson City and still awaiting for the Henceforth, administrator will revie files regularly to ensure compliance regulation.	e results. w employees'		
; ;	Based on record re failed to ensure 1 of background check to 449.188 (Employ	not met as evidence eview on 6/16/10, the of 6 employees met requirements of NR: yee #4 - signed crimi I state background c	facility S 449.176 nal history					
	This was a repeat State Licensure su	deficiency from the 8 rvey.	/19/09					
	Severity: 2 Scope	: 1						
Y 106 SS=D	449.200(2)(a) Pers	sonnel File - 1st aid 8	CPR	Y 106				
	residential facility r information require	ile for a caregiver of a must include, in addited and pursuant to subse	ion to the ction 1,		ter receipt of this statement of deficienci			

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Bureau c	f Health Care Quali	y and Compliance			· · · · · · · · · · · · · · · · · · ·		
	OF DEFICIENCIES OF CORRECTION	RECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		NVS430AGC	·			06/16/2010	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
SUNSHIN	IE CARE HOME	(1)		CYLAND AVE AS, NV 8912			
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETE	
Y 103	Continued From pa	ige 2		Y 103	· · · · · · · · · · · · · · · · · · ·		
	and annual signs a TB test and #6 - tw	nd symptoms, #5 - tv o step TB test).	wo step				
	This was a repeat of 8/19/09 State Licer	deficiency from the 6 nsure survey.	/3/09 and		(4)		
	Severity: 2 Scope	: 2					
Y 105 SS=D	449.200(1)(f) Perso	onnel File - Backgrou	ınd Check	Y 105			
	a separate personi member of the stat	wise provided in subs nel file must be kept : if of a facility and mu npliance with NRS 44	for each st include:				
	Based on record re failed to ensure 1 of background check to 449.188 (Employ	not met as evidence eview on 6/16/10, the of 6 employees met requirements of NRS yee #4 - signed crimi I state background cl	facility S 449.176 inal history				
	This was a repeat of State Licensure su	deficiency from the 8 rvey.	/19/09				
	Severity: 2 Scope	: 1				0.0	
Y 106 SS=D	449.200(2)(a) Pers	ionnel File - 1st ald 8	CPR	Y 106	-Please see photocopy of First Aid certification of employee #1. Hence	eforth. 71710	
	residential facility n	ile for a caregiver of a nust include, in addit and pursuant to subsec	ion to the] 	administrator will review personne ensure compliance.	I files to	

f deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING NVS430AGC 06/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3970 MARYLAND AVE **SUNSHINE CARE HOME** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) Y 106 Y 106 Continued From page 3 (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Based on record review on 6/16/10, the facility failed to ensure that 1 of 6 caregivers was trained in cardiopulmonary resuscitation (Employee #1). Severity: 2 Scope: 1 We are furnishing you herewith copies of the Y 152 Y 152 449.204(2) Insurance-BLC endorsement following insurance certificates: SS=C Certificate of Liability Insurance 08/05/09-08/05/10 Certificate of Property Insurance 08/05/09-08/05/10 NAC 449,204 2. A certificate of insurance must be furnished to the Division as evidence that the contract required by subsection 1 is in force and a license must not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a notice of 30 days to the bureau before the effective date of a cancellation or nonrenewal of the policy. This Regulation is not met as evidenced by: Based on interview and record review on 6/16/10, the facility failed to ensure a current certificate of insurance was available. Severity: 1 Scope: 3

I deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau o	f Health Care Qualit	ly and Compliance				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUR		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		NV8430AGC		B. WING _		06/16/2010
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY.	STATE, ZIP CODE	
CINCIMIC CARE UCME				YLAND AVI AS, NV 891:		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
Y 273	Continued From pa	age 4		Y 273		$\sim \Omega_{\rm D}$
SS=F	NAC 449.2175 4. A resident who I diet by a physician meal that complies administrator of the records of any modaccommodate for s	has been placed on a or dietitian must be p with the diet. The a facility shall ensure dification to the menu special diets prescribe an are kept on file for	special provided a that to ed by a	d f s	Resident #8, who is a diabetic and reliet was discharged on 6/21/10. To acility has no diabetic or a resident pecial diet. Henceforth, the facility dmit diabetic or a person that required ministrator will review residents insure strict compliance to this required.	that requires will no longer es special diet. files regularly to
Y 320 \$S=D	Based on observat the facility failed to diet to 1 of 1 reside (Resident #8). Severity: 2 449.220(1) Bedroo NAC 449.220 1. A bedroom door equipped with a loc motion from the ins	In a residential facilit ck must open with a s side unless the lock p	6/16/10, id renal il diet y which is single provides	¥ 320	The door lock of bedroom #1 was re6/30/10 and can be opened with a single Henceforth, Administrator will concurrence to the premises including ensure compliance. Please see attack	ngle motion. 7/7/6
	This Regulation is Based on observat failed to ensure 1 of be opened with a s	ility and can be operary special knowledge. not met as evidence tion on 6/16/10, the factor of 6 bedroom door lockingle motion (Bedroof ficiency from the 8/19)	d by: acility cks could om #1).			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 06/16/2010 **NVS430AGC** NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3970 MARYLAND AVE SUNSHINE CARE HOME LAS VEGAS, NV 89121 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID In (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The facility's fire extinguisher was inspected and recharged on 4/2/1/0. Please attached conies of Y 320 Y 320 Continued From page 5 invoice and tag. Henceforth, administrator will inspect fire extinguishers regularly to ensure Severity: 2 Scope: 1 compliance. Y 435 Y 435 449.229(4) Fire Extinguisher; Inspection SS=C NAC 449 229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to conduct such inspections. This Regulation is not met as evidenced by: Based on observation on 6/16/10, the facility failed to ensure that 1 of 1 facility fire extinguishers were inspected annually. Severity: 1 Scope: 3 Y 730 Y 730 449.2718(1)(a)(b) Fecal Impactions; The facility is making the necessary arrangements SS=F with the family of resident #5 for his immediate discharge from the facility. Administrator will see to it that no recident chall be admitted or allowed to NAC 449,2718 remain in the facility that requires manual removal of 1. A person who requires the manual removal of fecal impactions or the use of enemas or fecal impactions or the use of enemas or suppositories if the same can not provide the care for suppositories must not be admitted to a residential facility or be permitted to remain as a him of herealf resident of a residential facility unless: (a) The resident is able to provide the care for himself. (b) The care is administered according to the written instructions of a physician by a medical professional who has been trained to provide that care.

f deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiency and the continuation sheet 6 of 1

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI NVS430AGC		(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	
SUNSHIN	E CARE HOME			YLAND AV NS, NV 891		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
Y 730	Continued From p	age 6		Y 730		
	Based on observa		6/16/10, nts			
Y 773 SS=G	449.2726(1)(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2) Diabetes 449.2726 as diabetes must not dential facility or be pent of a residential facility or be pent of a residential facility or be pent of a residential facility of	be ermitted to illity formed sistance;	Y 773	Resident #8 was discharged 5/21/10. Please see attached Henceforth, the administrate dishetic resident shall be adjusted unless they can perthemselves without assistant responsible for the strict corregulation.	d discharge slip. or will see to it that no mitted nor remain in the form glucose testing for ce. He shall be
	Based on record re the facility did not a testing for 1 of 8 re	s not met as evidence eview and interview o ensure that blood glu- esidents was perform ves without assistanc	n 6/16/10, cose ed by the			
		admitted to the facility w on 6/16/10 Resider				

JUL 0 8 2010

BUREAU OF LICENSURE AND CERT HEAT ON LAS YESAS, NEVACE

Bureau o	f Health Care Qual	ity and Compliance				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MUILTII A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		NV9430AGC				06/16/2010
NAME OF P	ROVIDER OR SUPPLIER	ì			STATE, ZIP CODE	
ALMOUGH ALBE HAME				YLAND AVE AS, NV 8912	21 	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY LSC IDENTIFYING IMFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD BE COMPLETE
Y 773	Continued From pa	age 7		Y 773		
	her and recorded t	f1 checked her blood the reading on a log. not sure where the lo	Resident		* *	
	stated he pricked I blood and recorde Employee #1 was		ested h e r). ng the		Resident #8 was discharged from th	e facility on
Y 775 SS=G	A person who he admitted to a reside remain as a reside unless: (b) The resident's	Residents having dialess diabetes must not dential facility or be peent of a residential facomedication is administent himself without as	be rmitted to ility itered:	Y 775	y21/10. Henceforth, the facility widenit residents with diabetes. Admit esponsible for strict compliance to	ll no longer \alpha \(\begin{aligned} \text{\left} \\ \text{\left} \\ \text{\left} \text{\left} \\ \text{\left} \\ \text{\left} \\ \text{\left} \\ \text{\left} \\ \text{\left} \\ \text{\left} \text{\left} \\ \text{\left} \text{\left} \\ \text{\left} \q \text{\left} \\ \text{\left} \qu
	Based on resident on 6/16/10, the fac	a not met as evidence t interview and staff in cility did not ensure 1 tered insulin themselv ent #8).	terviews of 8			
	Resident #8 stated insulin injections. local hospital docuprescribed Lantus	edmitted to the facility d she was diabetic an A discharge documenumented Resident #8 18 units every night a	d was on nt from a was at bedlime		ter married of this etatoment of deficiency	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: NV\$430AGC NV\$430AGC NV\$430AGC NV\$430AGC NV\$430AGC STREET ADDRESS, CITY, STATE, ZIP CODE 3970 MARYLAND AVE LAS VEGAS, NV 89121 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED COMPLETED A. BUILDING B. WING O6/16/20	Bureau o	f Health Care Quali	ty and Compliance				
NWHE OF PROVIDER OR SUPPLIER SUNSHINE CARE HOME SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CRU) D SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MUST BE PRECEDED BY PULL TAG SUMMARY STATEMENT OF DEFICIENCIES TAG D PREFER REACH DEFICIENCY MUST BE PRECEDED BY PULL TAG SUMMARY STATEMENT OF DEFICIENCIES TAG D PREFER REQUILATORY DEFICIENCY MUST BE PRECEDED BY PULL TAG D PREFER PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE		(XI) HOTELSON		A. BUILDIN		(X3) DATE SURVEY COMPLETED	
SUNSHINE CARE HOME SUNSHINE CARE HOME SUNMARY STATEMENT OF DEFICIENCIES	L	····	NVS430AGC				06/16/2010
CAS PRICE CARE HOME LAS VEGAS, NV 89421	NAME OF P	ROVIDER OR SUPPLIER	,				
PREFER TAB REGULATORY OR LSC IDENTIFYING INFORMATION) Y775 Continued From page 8 and Novolog 3 units three times a day. Resident #8 stated Employee #1 filled her syringes with insulin and also injected her with the insulin. During an interview Employee #1, he stated he injected Resident #8 four times a day with insulin. He stated he injected the Novolog 3 units three times a day and at beditime he stated he injected Lantus 18 units. Employee #1 is the owner of the facility and occasionally worked as a caregiver in the facility. Employee #1 stated he also worked for a home health agency, so he thought it was acceptable for him to do the injections. Employee #1 stated he would request home health services for Resident #8. Severity: 3 Scope: 1 Y 791 449.2726(3)(b) Diabetes SS=F NAC 449.2726 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (b) Syringes and needles are disposed of appropriately in a sharps container of 10 f residenced by: Based on observation and interview on 8/16/10, the facility falled to ensure syringes and needles were disposed of appropriately in a sharps container of 1 of 1 residents (Resident #8)	SUNSHIN	E CARE HOME					·
and Novolog 3 units three times a day. Resident #8 stated Employee #1 filled her syringes with insulin and also injected her with the insulin. During an interview Employee #1, he stated he injected Resident #8 four times a day with insulin. He stated he injected the Novolog 3 units three times a day and at bedtime he stated he injected Lantus 18 units. Employee #1 is the owner of the facility and occasionally worked as a caregiver in the facility. Employee #1 stated he also worked for a home health agency, so he thought it was acceptable for him to do the injections. Employee #1 stated he would request home health services for Resident #8. Severity: 3 Scope: 1 Y 791 449.2726(3)(b) Diabetes NAC 449.2726 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place. This Regulation is not met as evidenced by: Based on observation and interview on 6/16/10, the facility failed to ensure syringes and needles were disposed of appropriately in a sharps container for 1 of 1 residents (Resident #8)	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETE
on the proper disposal of used svringes and needles. Used syringes and needles were disposed of in a new sharps container on 6/17/10 and kept inside the cabinet and locked. Please see attached pictures. Administrator will monitor and be responsible for the strict compliance to this regulation. This Regulation is not met as evidenced by: Based on observation and interview on 6/16/10, the facility failed to ensure syringes and needles were disposed of appropriately in a sharps container for 1 of 1 residents (Resident #8)	Y 775	and Novolog 3 unit #8 stated Employer insulin and also injected Resident # He stated he inject times a day and at Lantus 18 units. Effacility and occasio the facility. Employ for a home health acceptable for him Employee #1 state health services for	s three times a day. e #1 filled her syrings ected her with the ins v Employee #1, he sta to four times a day w ed the Novolog 3 uni bedtime he stated he mployee #1 is the ow mally worked as a ca vee #1 stated he also agency, so he though to do the injections, d he would request h Resident #8.	es with sulin. ated he ith insulin. Its three injected yner of the regiver in worked at it was	Y 775		\
container for 1 of 1 residents (Resident #8)	Y 791 SS=F	NAC 449.2726 3. The caregivers of facility with a reside ensure that: (b) Syringes and no appropriately in a stored in a safe plate. This Regulation is Based on observation that the facility failed to	employed by a reside ent who has diabetes eedles are disposed sharps container which ace. not met as evidence tion and interview on ensure syringes and	of ch is ed by: 6/16/10,	Y 791	on the proper disposal of used syringes and needles were disharps container on 6/17/10 and kerabinet and locked. Please see atta Administrator will monitor and be	nges and needles. 7/3/2 posed of in a new of inside the ched pictures. responsible for the
Unsecured under the sink in the laundry room). If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.	If deficiencies	container for 1 of 1 (needles were put unsecured under the	residents (Resident in a milk container st he sink in the laundry	#8) ored room).	in 10 days a	Iter receipt of this statement of deficience WQJZ11 RECEIVE	D. If continuation sheet 9 of 13

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Bureau c	t Health Care Quali	ty and Compilance					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM NVS430AGC		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 06/16/2010	
NAME OF D	ROVIDER OR SUPPLIER	HIOTOGRADO	STREET ADI	DESS CITY	STATE ZIP CODE	0010,2010	
	3970 MA			IDRESS, CITY, STATE, ZIP CODE RYLAND AVE AS, NV 89121			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
Y 791	Continued From pa	age 9		Y 791			
	Severity: 2	Scope: 3	İ				
Y 859 SS=D		c Physical examination	on of a		Resident #3 refused to take his phys despite repeated requests. He is voludischarging himself from the facility	on 7/3/10.	
	admission, or more significant change resident, the facility general physical ex his physician. The	on and each year after e frequently if there is in the physical condit y shall obtain the rest camination of the rest resident must be car structions provided by n.	a lon of a ilts of a dent by ed for	,	Henceforth. the facility will no longe without taking the required physical Administrator will insure compliance egulation.	r admit resident examination.	
	Based on record re the facility failed to received an annua This is a repeat de	not met as evidence eview and interview o ensure that 1 of 8 re I physical (Resident #	n 6/16/10, sidents !3).				
	Licensure Survey. Severity: 2 Scope	a. 1					
S			ı				
Y 895 SS≃C	449,2744(1)(b)(1)	Medication / MAR		Y 895			
			,		REC	EIVED	
	NAC 449,2744					0 6 2010	
	The administrate provides assistance administration of management	or of a residential fact te to residents in the nedication shall main medication administe	lain:		nunctil of 1 if his	ure and certification gas, nevada	

<u>Bureau of</u>	<u>Health Care Qual</u>	ity and Compilance					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SI GOMPLE	TEO
		NVS430AGC]		06/1	6/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
SUNSHIN	E GARE HOME		***	YLAND AVE AS, NV 8912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION TO ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE
	(1) The type of (2) The date ar administered; (3) The date ar or otherwise misse medication; and (4) Instructions medication to the	e record must include medication administed time that the medication at time that a residence, an administration for administering the resident that reflect the on of the resident's p	ered; cation was it refuses, of ene current	re re an Ci in to	sident #1 #2 #3 #4 #4 viewed and regularized nual survey on 6/16/10 aregivers were repeated portance of this regulal	immediately after the Please see attached con reminded of the strictly compliant be dealt with according residents' medication	ies. Thu
	Based on record realed to ensure the record (MAR) was (Resident #1, #2,	s not met as evidence eview on 6/16/10, the e medication adminis accurate for 8 of 8 r #3, #4, #5, #6, #7 an eficiency from the 8/1	e facility stration esidents d #8).				
	Severity: 1 Scop	e: 3					
Y 936 SS=E	449.2749(1)(e) Ro Tuberculosis	esident file-NRS 441/	4	Y 936 ✓	अमार १		
	resident of a resideast 5 years after facility. The file methat is resistant to unauthorized use	must be maintained the lential facility and return the permanently leave ust be kept locked in fire and is protected. The file must contains	ained for at yes the n a place against ain all				
If deficiencies		d plan of correction must!	be returned wit		fter receipt of this statement WQJZ11	nt of deficiencies.	tion sheet 11 of
さいいき しんばん	**				TT 14(V4-11)		

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Bureau c	<u>f Health Care Quali</u>	ty and Compliance				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NVS430AGC		B. WING_		06/16/2010
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	
			(YLAND AV AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL,	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE ROPRIATE DATE
Y 936	information and an the resident, includ (e) Evidence of cor	age 11 sessments, medical y other information re ing without limitation: npliance with the pro RS and the regulation	visions of	1 930]	Resident #5 refused to take the requivecessary arrangements with the faure ndertaken for his immediate discharacility. While resident #8 was disched 121/10. Henceforth, the facility will denitting residents without taking the ests and be permitted to remain in the deministrator will monitor strict congequation.	nilv is being ge from the arged on II refrain from e required TB ae facility.
烬	Based on record re failed to ensure 2 on NAC 441A.380 reg (Resident #5 and #	deficiency from the 8 rvey.	facility ed with esting			
Y1010 SS=E	residential facility for illnesses shall, with employed at the fa- hours of training co	ovides care for a restor persons with mentain 60 days after he builty, attend not less procerning care for restorm mental illnesses	al ecomes than 8 sidents	Y1010V	Employee #3 and #4 have taken the Training on 07/02/10. Please see at certificates. Henceforth, administratemployee's files on a regular basis to compliance to this requirement.	ttached copies of
	Based on record re failed to ensure 2 of hours of training co who are suffering f	not met as evidence eview on 6/16/10, the of 6 employees had noncerning care for re- from mental illnesses	facility eceived 8 sidents		fler receipt of this statement of deficienci	

STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU NVS430AGC	ER/CLIA IMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/16/2010
NAME OF PROVIDER OR SUPPLIE		STREETA	DDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>
			ARYLAND AVE GAS, NV 89121	i	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCE NCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	full	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLI THE APPROPRIATE DATE
Y1010 Continued From	page 12		Y1010		
(Employee #3 ar	n d #4).				
Severity: 2 Sco	ppe: 2				
					RECEIVED
					JUL 0 5 2010
deficiencies are cited, an approv	ved plan of correction must b	e returned v		SURE r receipt of this statement of o QJZ11	U OF Incresing And Committee deficiencies Nevals If continuation sheet 1:

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